



Health Policy for Low-Income People in Maryland

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A unique combination of bold innovation and strong regulatory involvement characterizes health care policy in Maryland. The state has used Medicaid rather than a separate state-designed program to pursue coverage expansions, including the recent Children's Health Insurance Program (CHIP), and has been aggressive in enrolling beneficiaries under capitated managed care. Maryland's group insurance market reforms were compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) before the federal law was enacted, and the state has arguably the strongest hospital market regulatory system and managed care consumer protections in the United States.

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growth is slower than the national average (4.3 percent vs. 5.2 percent for the United States between 1991 and 1996).¹ The American Association of Retired Persons projects that in 2010, seniors will account for just 11.7 percent of the state population, compared with 13.3 percent for the United States.²

Maryland's biggest city is Baltimore, which is the 14th largest city in the United States by population.³ The Baltimore–Washington, D.C., combined metropolitan statistical area (MSA), which encompasses the District of Columbia's densely populated suburbs in Maryland and Virginia, is the nation's fourth largest MSA, behind New York, Los Angeles, and Chicago.

A lower share of Maryland residents live in nonmetropolitan areas (10.5 percent) than is the case for the United States as a whole (21.8 percent).

State Characteristics

Sociodemographic Profile

With 5.1 million residents, Maryland is the nation's 20th most populous state. Its population includes a much higher share of African Americans than the United States as a whole (28.4 vs. 12.5 percent) and a lower share of whites (65.2 vs. 72.6 percent) and Hispanics (3.1 vs. 10.7 percent) (table 1). The state mirrors the nation in terms of age, with seniors representing 12 percent and children representing 26 percent of the population. Maryland's rate of population

Economic Indicators

Maryland's economy is dominated by the service sector, including retail trade, finance, transportation, and construction. The state boasts the highest concentration of research and development facilities, the third-highest concentration of biotech companies, and the highest concentration of scientists and engineers in the United States.⁴ Its largest employers include the National Institutes of Health, the University of Maryland system, and the Johns Hopkins University. Reflecting its proximity to the nation's capital, Maryland has a concentration of government

Table 1
State Characteristics

	<u>Maryland</u>	<u>United States</u>
Sociodemographic		
Population (1994–95) ^a (in thousands)	5,006	260,202
Percent under 18 (1994–95) ^a	25.8%	26.8%
Percent 65+ (1994–95) ^a	12.1%	12.1%
Percent Hispanic (1994–95) ^a	3.1%	10.7%
Percent Non-Hispanic Black (1994–95) ^a	28.4%	12.5%
Percent Non-Hispanic White (1994–95) ^a	65.2%	72.6%
Percent Non-Hispanic Other (1994–95) ^a	3.4%	4.2%
Percent Noncitizen Immigrant (1996) [*]	5.1%	6.4%
Percent Nonmetropolitan (1994–95) ^a	10.5%	21.8%
Population Growth (1995–96) ^b	0.6%	0.9%
Economic		
Per Capita Income (1996) ^c	\$27,618	\$24,426
Percent Change in Per Capita Personal Income (1995–96) ^c	4.0%	4.6%
Percent Change in Personal Income (1995–96) ^c	4.7%	5.6%
Employment Rate (1997) ^{d, e}	67.7%	63.8%
Unemployment Rate (1997) ^d	5.1%	4.9%
Percent below Poverty (1994) ^f	9.9%	14.3%
Percent Children below Poverty (1994) ^f	15.0%	21.7%
Health		
Vaccination Coverage of Children Ages 19–35 Months (1996) ^{g, h}	78.0%	77.0%
Low Birth-Weight Births (<2,500 g) (1995) ⁱ	8.5%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1996) ^j	8.4	7.2
Premature Death Rate (Years Lost per 1,000) (1995) ^k	53.8	46.7
Violent Crimes per 100,000 (1996) ^l	931.2	634.1
AIDS Cases Reported per 100,000 (1996) ^m	44.4	25.2
Political		
Governor's Affiliation (1998) ⁿ	D	
Party Control of Senate (Upper) (1999) ^o	32D-15R	
Party Control of House (Lower) (1999) ^o	106D-35R	

a. Two-year concatenated March Current Population Survey (CPS) files, 1995 and 1996. These files are edited using the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.

b. U.S. Bureau of the Census, *Statistical Abstract of the United States: 1997* (117th edition). Washington, DC, 1997. 1995 population as of April 1. 1996 population as of July 1.

c. Bureau of Economic Analysis, U.S. Department of Commerce, January 1998.

d. U.S. Department of Labor, *State and Regional Unemployment, 1997 Annual Averages*. USDL 98-78. Washington, DC, February 27, 1998.

e. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.

f. CPS three-year average (March 1994–March 1996, where 1994 is the center year) edited using the Urban Institute's TRIM2 microsimulation model.

g. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. "National Immunization Survey, 1996." *Morbidity and Mortality Weekly Report* 46(29). Hyattsville, MD, July 25, 1997.

h. 4:3:1:3 series: four or more doses of DTP/DT, three or more doses of poliovirus vaccine, one or more doses of any MCV, and three or more doses of *Haemophilus influenzae* type b vaccine.

i. S.J. Ventura, J.A. Martin, S.C. Curtin, and T.J. Mathews. "Advance Report of Final Natality Statistics, 1995." *Monthly Vital Statistics Report* 45(11), supp. Hyattsville, MD: National Center for Health Statistics, 1997.

j. National Center for Health Statistics. "Births, Marriages, Divorces, and Deaths for June 1996." *Monthly Vital Statistics Report* 45(12). Hyattsville, MD: Public Health Service, 1997.

k. Rate was calculated using years of potential life lost from age 65 (National Center for Health Statistics. Multiple Cause of Death Mortality Tapes, 1995) as the numerator and population estimates (U.S. Bureau of the Census. ST-96-1. Estimates of the Population of States: Annual Time Series, July 1, 1990–July 1, 1996) as the denominator.

l. U.S. Department of Justice, FBI. *Crime in the United States*, 1996. September 28, 1997.

m. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report* 8(2), 1996.

n. National Governors' Association. *The Governors, Political Affiliations, and Terms of Office*, 1998. January 15, 1997.

o. National Conference of State Legislatures Web site: www.ncsl.org. D indicates Democrat and R indicates Republican.

* Three-year concatenated March Current Population Survey (CPS) files, 1996–98, where 1996 is the center year.

These files are edited by the Urban Institute to correct misreporting of citizenship.

contractors, including large defense contractors such as Lockheed Martin and Northrop Grumman.

In 1996, 73 percent of the civilian workforce held nonmanufacturing service jobs; 19 percent held jobs in federal, state, or local government; and 8 percent held manufacturing jobs.⁵ National trends—including lower defense spending and contracting, reductions in federal employment, and an increase in corporate mergers and acquisitions—have contributed to changes in the state economy over the past decade, including shifts away from higher-wage positions in established industries toward the high-technology sectors and lower-paying service jobs without health benefits. Between 1996 and 1997, Maryland saw 46,000 new jobs created. Service sector jobs increased by 5 percent, accounting for 33,000 new jobs. For the first time since the reduction in defense spending in the 1980s, manufacturing jobs increased, but only by 0.5 percent (fewer than 1,000 jobs).⁶

Maryland ranks fifth among states in per capita income. In 1996, the state's per capita income (\$27,618) was 13 percent higher than the national average (\$24,426), but the state's rate of income growth (4.0 percent) lagged behind the national rate (4.6 percent), and unemployment is higher in Maryland (5.1 percent) than the United States as a whole (4.9 percent) (table 1). In 1994, a substantially smaller share of Maryland residents lived below the federal poverty level (FPL) than in the United States as a whole (9.9 percent vs. 14.3 percent), and far fewer of the state's children lived in poverty (15.0 percent vs. 21.7 percent). Per capita incomes vary considerably across the state. Montgomery County, which includes some of Washington, D.C.'s most affluent suburbs, had a per capita income of \$37,640 in 1997, twice that of rural Worcester County (\$18,824) in the southeastern part of the state.⁷

Health Indicators

Compared to national averages, Maryland's major population health indicators are mixed. The state's rate of heart disease deaths per 100,000 residents (236) is 16 percent lower than that of the nation; the rate of stroke deaths per 100,000 (53) is 13 percent lower; and the rate of alcohol-related deaths per 100,000 (39) is 7 percent lower.⁸ How-

ever, other indicators suggest some major public health problems. Maryland reported a 76 percent higher incidence of AIDS cases than the United States (44.4 vs. 25.2 per 100,000) in 1996; its infant mortality rate (8.4 deaths per 1,000 live births) is 17 percent higher than the national rate (7.2); and the incidence of violent crimes is 47 percent higher (table 1). Reflecting these problems, Maryland's premature death rate (53.8 years of life lost before age 65 per 1,000 population) was 15 percent higher than the national rate (46.7) in 1995.

Politics

Maryland is one of few states to have a Democratic governor and strong Democratic majorities in both houses of the legislature. Democrats hold more than two-thirds of the Senate (32-15) and the House of Delegates (106-35). Governor Parris Glendening, a former county executive, first won election in 1994 over former House Minority Leader Ellen Sauerbrey (R). Glendening, a rare example of a Maryland politician from outside the Baltimore area rising to prominent statewide office, won another tightly contested race against Sauerbrey for election to a second term in 1998.

In national elections, Maryland also has voted for Democrats in recent years. President Bill Clinton won 54 percent of the popular vote in 1996 compared with 38 percent for Senator Bob Dole (R).⁹ Both U.S. Senators are Democrats, first winning election in 1976 and 1986, respectively. However, four of Maryland's eight members of the U.S. House of Representatives are Republicans.

Health Insurance Market

Maryland has relatively high health maintenance organization (HMO) penetration, both in the private market and among Medicaid beneficiaries. In 1994, 36 percent (1.8 million) of all state residents were enrolled in HMOs¹⁰ and by 1996, the figure had increased to 47 percent. Maryland's HMO enrollment is less concentrated in major urban areas than is the case in other states. Baltimore had a lower HMO penetration rate in 1997 (37 percent) than the state average, while the state's smaller metropolitan areas had above-average penetration rates. However, HMO enrollment in the Baltimore area is rising fast, increasing 15 percent

(from 806,000 to 924,000) between January and July 1997.¹¹

Blue Cross/Blue Shield (BCBS) insurers, counted together, dominated the state's group and individual insurance markets as of 1995,¹² and commercial HMOs held a significant share of group business. Conventional (non-HMO) BCBS plans wrote an estimated 43 percent of group market business, and BCBS HMOs wrote an additional 15 percent. Conventional BCBS plans wrote an estimated 62 percent of individual market business, and BCBS HMOs wrote another 15 percent. Commercial HMOs together wrote about 34 percent of group market business and 16 percent of individual market business. Conventional commercial insurers wrote just 8 percent of group market business and 7 percent of individual business. The largest single plan in the state, Blue Cross/Blue Shield of Maryland, holds an estimated 55 percent of the individual market's business and an estimated 38 percent of the group market.¹³

In January 1999, BCBS of Maryland and BCBS of the National Capital Area merged to become CareFirst BCBS, the seventh-largest Blues plan in the country. The arrangement makes the plans wholly owned subsidiaries of CareFirst, Inc., a nonprofit holding company—allowing each plan to operate in its service area under existing regulatory oversight. The insurers believe that combining their sales forces, products, and medical networks will create a more efficient and competitive health plan. Consumer groups opposed the merger but were unable to block it. One major concern was to protect the plans' charitable assets in the event that CareFirst converted to for-profit status. BCBS of Delaware recently agreed to join CareFirst, pending regulatory approval. This addition would increase CareFirst's membership to 2.5 million enrollees.

Hospital Market

There are no public hospitals in Maryland, largely because the state's rate-setting system builds an allowance for uncompensated care into hospital rates. There are just eight for-profit hospitals out of approximately 80 statewide, only one of which is an acute care facility. Baltimore's only for-profit hospital out of 25 hospitals—and its only psychiatric hospital—filed for bankruptcy and closed in 1998.¹⁴

Maryland has not seen the major consolidations and layoffs that other states have experienced, in part because the state's unique rate-setting system (discussed below) sets the hospital rates charged to all payers to account for the costs of providing uncompensated care, reducing financial pressure on hospitals. Critics of rate setting complain that, by design, a lack of competition maintains overcapacity in the system.

Still, Maryland's hospital market has experienced an increase in mergers and affiliations in recent years, as providers seek to gain more leverage in negotiations with managed care plans. Major facilities face pressure to bolster outpatient capacity in order to protect their patient base during the continuing shift away from inpatient care. Consistent with the national trend, state spending on inpatient care dropped 5.7 percent in 1997 and outpatient spending increased 11 percent.¹⁵ About 75 percent of hospitals in the state have formed affiliations, and many remaining hospitals are pursuing mergers. But, as in other areas of the country, many of these mergers will not result in significant downsizing or cost cutting.

Health Insurance Coverage

Detailed Insurance Trends

Maryland's rate of uninsured among the nonelderly (14.4 percent) is slightly lower than the national rate (15.5 percent) (table 2). The state has a substantially higher rate of employer-based coverage (72.2 percent vs. 66.1 percent for the nation), while Medicaid covers a lower share of the state population than the country as a whole (9.3 percent vs. 12.2 percent). The fact that fewer Maryland residents are eligible for Medicaid (17.6 percent vs. 19.4 percent for the nation) partly explains the program's low rate of coverage. More telling, however, is the fact that the state enrolls a substantially lower share of eligibles (67.6 percent) than the nation as a whole (81.2 percent),¹⁶ suggesting an opportunity for more effective outreach and enrollment efforts.

Medicaid Eligibility

Maryland first expanded Medicaid eligibility substantially above the federal minimums in 1987, covering pregnant

Table 2
Health Insurance Coverage

Health Insurance, 1994–95	Maryland	United States
Nonelderly Population		
Percent Uninsured ^a	14.4 %	15.5 %
Percent Medicaid ^a	9.3	12.2
Percent Employer-Sponsored ^a	72.2	66.1
Percent Other Health Insurance ^{a, b}	4.2	6.2
19–64 Population		
Percent Uninsured ^a	16.9	17.9
Percent Medicaid ^a	4.9	7.1
Percent Employer-Sponsored ^a	73.3	67.8
Percent Other Health Insurance ^{a, b}	5.0	7.2
0–18 Population		
Percent Uninsured ^a	8.6	10.4
Percent Medicaid ^a	19.4	23.1
Percent Employer-Sponsored ^a	69.7	62.5
Percent Other Health Insurance ^{a, b}	2.4	4.0
<200 Percent of the Federal Poverty Level, Nonelderly Population		
Percent Uninsured ^a	24.9	25.3
Percent Medicaid ^a	30.9	34.1
Percent Employer-Sponsored ^a	40.2	33.9
Percent Other Health Insurance ^{a, b}	4.0	6.7

a. Two-year concatenated March Current Population Survey files, 1995 and 1996. These files are edited using the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.
b. "Other" includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.

women and infants to 185 percent of the FPL. By 1998, the program also had expanded coverage to children through age 14 to 185 percent of the FPL. However, the program did not expand coverage to older adolescents and adults above 34 percent of the FPL, which was the state's threshold for cash payments under Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF) as of July 1996. Maryland's CHIP expansion (discussed below), approved in mid-1998, further increased Medicaid eligibility to 200 percent of the FPL for all children through age 18. As of 1994, Maryland was one of 36 states to cover the medically needy.¹⁷ The maximum income (net of medical expenditures) for eligibility under this category depends on family size but averages about 40 percent of the FPL, which is lower than average (50 percent of the FPL) among states covering this group.¹⁸

Medicaid Expenditures

Like many other states, Maryland experienced high Medicaid expenditure growth in the early 1990s. Total state and federal expenditures increased 16.7 percent per year between 1990 (\$1.2 billion) and 1995 (\$2.5 billion) (table 3). Medicaid expenditures accounted for 17.7 percent of state general-fund expenditures in 1995 and an even higher share of total state spending (18.5 percent), which also includes other state funds and federal aid. Medicaid spending had accounted for only 10.3 percent of general-fund expenditures as recently as 1990. Below-average enrollment growth between 1990 and 1994 and an absolute decline in each enrollment category between 1994 and 1996 (table 4) have helped Maryland avoid an even faster growth in Medicaid expenditures.

Maryland's per capita Medicaid costs are higher than the national average for each of the program's four enrollment categories—the elderly, the blind and disabled, adults, and children.

Maryland spends 7 percent more on each elderly beneficiary and 21 percent more on each blind and disabled beneficiary (table 4). The state spends 30 percent more than the national average for each adult and 35 percent more for each child, but these eligibility categories account for less than a third of all Medicaid expenditures.

Unlike many states, Maryland has not seen disproportionate expenditure growth among elderly beneficiaries in recent years. In fact, Medicaid expenditures on elderly beneficiaries increased only 8 percent between 1992 and 1996, compared to a 21 percent increase for the United States as a whole. Spending on long-term care (LTC) services for the elderly—a line item that has contributed substantially to Medicaid spending increases in some states—increased more slowly between 1992 and 1994 (4.8 percent per year compared to 7.1 percent for the nation) and declined 1.5 percent per year between 1994 and 1996, when the U.S. annual growth rate was 4.6 percent. Spending on LTC services for the blind and disabled, by contrast, has grown faster than the national average.¹⁹

Current State Health Policy Issues

Medicaid Managed Care

Maryland has been one of the most active states in implementing Medicaid managed care. The state first allowed voluntary enrollment of noninstitutionalized Medicaid beneficiaries in HMOs in 1975, but the major push toward managed care came in the early 1990s. The factors driving Medicaid reform included a budget crisis caused by the national recession and Maryland's heavy loss of defense-related jobs during the reductions in U.S. military spending. Job losses, combined with federally mandated expansions of Medicaid eligibility and increasing health care costs, created unsustainable pressures on the program. Medicaid enrollment had increased from 340,000 in the late 1980s to 440,000 in 1994,²⁰ and per-enrollee costs also were rising by double-digit percentages. As the program began to consume a rapidly increasing share of state funds, it became a prime target for budget cuts.

The state developed a primary care case management (PCCM) program,

called Maryland Access to Care (MAC), under a Section 1915(b) waiver in 1991 and assigned all beneficiaries (except dual eligibles, voluntary HMO enrollees, and institutionalized beneficiaries) to a primary care provider who would serve as a gatekeeper for specialty care. By December 1992, one year after its implementation, MAC covered about 70 percent (300,000) of all Medicaid beneficiaries.²¹

In 1992, Maryland designed and partially implemented an initiative to manage high-cost Medicaid cases. The impetus behind this reform was a 1992 Department of Health and Mental Hygiene (DHMH) report indicating that 5 percent of Medicaid beneficiaries accounted for about 50 percent of program spending and 10 percent accounted for 70 percent of spending. The High-Cost User Initiative, first implemented in 1994, aimed to allow physician case managers greater flexibility in designing the most effective combina-

tions of treatment for high-cost patients. The initiative also introduced financial incentives under which facilities and doctors who provided care would share any realized savings with the Medicaid program.²² The initiative was stalled by difficulties in developing and implementing the management systems for high-cost cases; it was derailed by the replacement of DHMH's secretary after Governor Glendening's 1994 election.

The state's drive toward mandatory enrollment in capitated managed care came in 1997. The program's goal was to achieve spending cuts and cost certainty, as well as to provide a medical home for beneficiaries. In April, Maryland enacted a law mandating enrollment in HMOs or other capitated managed care plans under the state's Section 1115 waiver, which the Health Care Financing Administration (HCFA) had approved in October 1996. Under HealthChoice, the mandatory enrollment program, all Medicaid recipients

except dual eligibles, institutionalized beneficiaries, and those receiving care under the state's Model Waiver or Family Planning Waiver are enrolled in HMOs.²³ A distinctive feature of HealthChoice is the inclusion of the disabled and chronically ill.

In June 1996, roughly the same number (300,000) of Maryland's Medicaid beneficiaries were enrolled in some form of managed care as in 1992. Some 120,000 (26 percent) of these beneficiaries were enrolled in HMOs under fully capitated contracts, and 36 percent of Baltimore's beneficiaries were enrolled in HMOs.²⁴ The state began implementing HealthChoice in June 1997; by November 1997, when the initial enrollment was completed, 315,000 beneficiaries (75 percent of enrollees) had enrolled in capitated managed care plans.²⁵

Key features of the HealthChoice program include a one-time guaranteed six-month period of eligibility, guaran-

Table 3
Maryland Spending
by Category, 1990 and 1995
(\$ in Millions)

Program	State General-Fund Expenditures ^a			Expenditures ^b		
	1990	1995	Annual Growth	1990	1995	Annual Growth
Total	\$6,060	\$7,054	3.1%	\$11,041	\$13,496	4.1%
Medicaid ^{c,d}	627	1,246	14.7	1,152	2,491	16.7
% of Total	(10.3)	(17.7)	—	(10.4)	(18.5)	—
Corrections	288	586	15.3	316	653	15.6
% of Total	(4.8)	(8.3)	—	(2.9)	(4.8)	—
K-12 Education	1,706	2,047	3.7	1,898	2,341	4.3
% of Total	(28.2)	(29.0)	—	(17.2)	(17.3)	—
AFDC	127	137	1.5	284	312	1.9
% of Total	(2.1)	(1.9)	—	(2.6)	(2.3)	—
Higher Education	821	789	(0.8)	1,595	1,957	4.2
% of Total	(13.5)	(11.2)	—	(14.4)	(14.5)	—
Miscellaneous ^e	2,491	2,249	(2.0)	5,796	5,742	(0.2)
% of Total	(41.1)	(31.9)	—	(52.5)	(42.5)	—

Source: National Association of State Budget Officers, 1992 State Expenditure Report (April 1993) and 1996 State Expenditure Report (April 1997).

a. State spending refers to general-fund expenditures plus other state-fund expenditures for K-12 education.

b. Total spending for each category includes the general fund, other state funds, and federal aid.

c. States are requested by the National Association of State Budget Officers (NASBO) to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as "other state funds." In some cases, however, a portion of these taxes, fees, etc., do get included in state spending because states cannot separate them. Maryland reported \$9 million in state expenditures in 1990 and \$14 million in 1995.

d. Total Medicaid spending will differ from data reported on the HCFA 64 for three reasons: First, NASBO reports on the state fiscal year and the HCFA 64 on the federal fiscal year; second, states often report some expenditures, e.g., mental health and/or mental retardation, as "other health" rather than Medicaid; third, local contributions to Medicaid are not included, but would be part of Medicaid spending on the HCFA 64.

e. This category includes all remaining state expenditures (i.e., environmental projects, transportation, housing, and other cash assistance programs) not captured in the five listed categories.

teed participation for historic providers of care to Medicaid beneficiaries, risk-adjusted capitation rates for health plans, a mental health services carve-out administered by DHMH, a local ombudsman program to help with relations between beneficiaries and plans, and state-administered enrollment with prohibitions on direct plan marketing. All HealthChoice beneficiaries are sent enrollment materials by mail and given the opportunity to select a participating plan and primary care physician. The program automatically assigns beneficiaries who do not exercise this option a plan and provider within 21 days.

As of August 1998, eight managed care organizations—including established commercial HMOs and newer provider-sponsored plans²⁵—served Medicaid beneficiaries under HealthChoice. Some HMOs, including the plan with the highest capitated Medicaid enrollment before HealthChoice, have declined to participate in the program, citing low capitation rates and excessive regulation. State law requires Medicaid managed care plans to pay either a capitated fee or cost-related reimbursement to federally qualified health centers (FQHCs) with which

they contract. In cases of underpayment, the FQHC can ask DHMH to withhold that portion of the plan's capitation payment, and the state can pay the FQHC directly.²⁶

Reforms have produced smaller savings than expected. Advocates have successfully lobbied for required services and safeguards to protect Medicaid beneficiaries, which add to the cost of care. Hospitals have not been fully exposed to cost-cutting pressures because they are partially protected by rate setting. Both of these factors—a rich benefits package and fixed payments to providers—have helped prevent plans' capitation rates from declining. In addition, DHMH substantially overpaid plans participating in HealthChoice in 1997 and 1998, when it mistakenly used an extra year of data in estimating the number of enrollees with chronic health conditions. A subsequent review by the Department of Budget and Management revealed additional errors in the calculation of plans' capitation payments, highlighting the difficult challenges of risk adjustment, which include the need for good encounter data and the capacity to use it effectively.

Children's Health Insurance Program

In July 1998, HCFA approved Maryland's CHIP plan to expand coverage to low-income children through Medicaid. The program covers children through age 18 to 200 percent of the FPL.²⁷ In CHIP's second year, which starts in July 1999, the state plans to require premium contributions of 1 to 2 percent of household income from families between 185 and 200 percent of the FPL. It also will require families of CHIP eligibles who are above 185 percent of the FPL to purchase employer-based dependent coverage when it is available and meets specific cost and coverage criteria.

Largely through increased outreach, Maryland hopes to expand coverage under CHIP to about 60,000 uninsured children, including 15,500 newly eligible children between 185 and 200 percent of the FPL or over age 14. According to one study, there are currently not enough uninsured children under 200 percent of the FPL for the state to spend down its allotment of federal CHIP funds.²⁸ As of November 1998, the program had enrolled 31,000

Table 4
Medicaid Enrollment
and Expenditures per Enrollee:
Contributions to Total Expenditure Growth

	Maryland				United States			
	1996	Average Annual Growth			1996	Average Annual Growth		
		1990–92	1992–94	1994–96		1990–92	1992–94	1994–96
Elderly								
Total expenditures on benefits (millions)	\$521.3	17.9%	4.4%	−1.3%	\$42,418.5	16.7%	8.3%	6.2%
Enrollment (thousands)	47.0	4.6	1.6	−2.4	4,103.2	5.1	4.0	0.3
Expenditures per enrollee	\$11,094	12.7	2.7	1.2	\$10,338	11.0	4.2	5.8
Blind and Disabled								
Total expenditures on benefits (millions)	\$1,032.1	25.8	13.4	8.2	\$56,601.3	17.6	13.8	10.5
Enrollment (thousands)	101.0	9.2	16.4	−0.5	6,698.2	9.8	10.8	5.8
Expenditures per enrollee	\$10,220	15.3	−2.7	8.8	\$8,450	7.1	2.7	4.4
Adults								
Total expenditures on benefits (millions)	\$263.3	23.5	5.3	−1.4	\$16,956.6	21.4	9.2	4.8
Enrollment (thousands)	110.3	10.0	1.6	−3.6	9,225.0	11.4	6.8	−1.5
Expenditures per enrollee	\$2,388	12.2	3.7	2.2	\$1,838	8.9	2.2	6.3
Children								
Total expenditures on benefits (millions)	\$486.4	23.1	7.4	9.1	\$24,313.8	23.8	12.8	6.5
Enrollment (thousands)	315.5	11.4	4.5	−1.2	21,270.5	13.1	6.6	−0.1
Expenditures per enrollee	\$1,542	10.6	2.8	10.4	\$1,143	9.5	5.8	6.7

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

children, including about 2,000 children between 185 and 200 percent of the FPL.²⁹ This number represents a much higher share of eligibles than most other states. Program officials attribute this success to an aggressive marketing and outreach effort. Advocates claim that enrollment of nearly half of eligible children in less than six months is impossible and indicates that there are more uninsured children below 200 percent of the FPL than had been estimated.³⁰

Insurance Market Reforms

Maryland first enacted comprehensive small-group insurance reforms in 1993, including guaranteed issue of all insurance products for groups of 1 to 50 and modified community rating. The latter bars rating for health status or claims experience; rate variation for age, geography, and family composition may not exceed 38 percent.³¹ The state also enacted a ban on all preexisting condition exclusions, which is strong compared to the laws in most states that allow look-back and waiting periods.

Maryland was compliant with HIPAA's small-group provisions by the time the federal law was enacted. In response to HIPAA's individual market requirements, Maryland adopted the federal fallback option for group-to-individual portability in 1997. This option guarantees issue of a basic and standard benefits plan to all HIPAA eligibles. The state also enacted guaranteed renewal in the individual market (as required by HIPAA) and extended to all individuals the restrictions on preexisting condition exclusions that federal law required for HIPAA eligibles. Maryland is among the majority of states that have not enacted guaranteed issue or rate restrictions in the individual market.

Hospital Rate Setting

Maryland is the only state that operates an all-payer hospital rate-setting system. The state began setting hospital rates for private payers in 1974 and received a federal waiver from HCFA in 1977 to allow Medicaid and Medicare to participate. Three other states (Massachusetts, New Jersey, and New York) operated all-payer rate-setting systems for over a decade but abandoned them between 1991 and 1996.

Maryland's Health Services Cost Review Commission (HSCRC) uses an inflation adjustment system to set fee-for-service hospital rates annually, based on national price updates of factors such as medical equipment, salaries, and supplies. Rates are then adjusted to include the provision of uncompensated care and to reward (or penalize) hospitals whose per-case charges are below (or above) average. The rates also include a system correction factor (SCF) to account for differences between state and national costs. Since 1995, Maryland's charges per case have exceeded national costs; therefore, the SCF has been negative, reducing the growth of hospital rates. The Maryland Hospital Association (MHA) has strongly opposed the annual inflation adjustments in recent years.

In an attempt to make the rate-setting system more flexible, the state has allowed payers and hospitals to negotiate some at-risk contracts, marking a departure from the fee-for-service model of hospital reimbursement. HSCRC will approve capitated rates if it believes a negotiated arrangement will reduce utilization and overall costs, rather than simply lower payments to hospitals. Although rate setting affords hospitals significant protections from payers who want to cut rates for specific services or impose per diem rate structures, it no longer totally shields them from cost-containment pressures.

The rate-setting system enjoyed long-standing support by successfully controlling hospital cost growth and distributing the financial burden of charity care across all payers, but it has been less successful in recent years. Hospital costs per case were 26 percent above the national average in 1976, the year before the all-payer system went into effect, and fell to 12 percent below the average by 1992. However, beginning in 1993, hospital costs rose by more than the national average for five years in a row and now stand about 3 percent above the United States as a whole.³²

Hospitals have supported the reforms, even though they will lower rates, because they are crucial to retaining patients and sustaining the core inflation adjustment system. Nevertheless, MHA has expressed concern that the reforms may force hospitals to curtail services and cut staff. Meanwhile,

the state's HMOs remain adamant that the entire hospital rate-setting system should be scrapped in favor of negotiated rates, arguing that a competitive market for hospital services will promote efficiency and innovation.

Some state policymakers who have been longtime supporters of rate setting are calling for modifications to the system to increase competition. Opponents of reform argue that deregulation would allow large commercial health plans to avoid sharing the cost of uncompensated care for Maryland's uninsured. Maryland's allowance for charity care, built directly into the hospital rate formulas, totaled \$436 million (8 percent of total hospital revenues) in 1997.³³ Retaining support for charity care remains a priority as the legislature prepares to debate reform and possible repeal of the rate-setting system during the 1999 session.

Consumer Protection

Maryland's track record on consumer protection under health insurance and managed care plans predates the national trend of the past two years. To date, Maryland has enacted more benefit mandates than any other state. In 1993, the state enacted the nation's first mental health parity law to include treatment for substance abuse and chemical dependency in addition to mental illness and emotional disorders. In 1997, the legislature added six conditions—including osteoporosis, diabetes, and prostate cancer—to the list that all health plans must cover, bringing the total to 45.³⁴ In 1998, Maryland enacted laws making it one of 20 states to require an independent appeals process for grievances against HMOs³⁵ and requiring HMOs to offer internal grievance procedures for members and health care providers.³⁶

More consumer protections could soon be added to the list. In July 1998, Governor Glendening proposed new requirements that would increase access to specialty care by requiring HMOs to refer patients out of network when there is no adequate provider within the network, allowing specialists to serve as primary care physicians, allowing standing referrals to specialists, and establishing an ombudsman office to help consumers exercise their rights within managed care plans.³⁷ The long and

growing list of mandated protections has prompted some concern among policymakers, and in 1998 the state enacted laws requiring a cost analysis and an impact study of current and proposed mandated benefits.³⁸

Maryland's HMOs have complained that the state's mandated benefits make them less competitive than District of Columbia- and Virginia-based health plans in attracting federal government employees,³⁹ 130,000 of whom live in Maryland.⁴⁰ There also has been concern among policymakers that large employers are self-insuring and buying stop-loss insurance policies (which make it easier to self-insure by protecting employers from catastrophic costs) in order to avoid covering state-mandated benefits. The state had attempted to limit stop-loss claims in the hopes of keeping employers in the private insurance market, where benefits packages are subject to state regulation, but a federal appeals court ruled in 1997 that this restriction would violate the Employee Retirement Income Security Act of 1974 preemption of state regulation of employee benefits. In June 1998, the U.S. Supreme Court refused to consider the state's appeal of this ruling.⁴¹

Maryland also has been a leader in measuring the performance of health plans. In September 1998, the Health Care Access and Cost Commission released its second annual HMO report card, a guide to consumer satisfaction that also compares performance across plans in a number of clinical categories. Advocates and some state officials praise the guides as efficient vehicles for distributing important information on health plans to the public and as evolving tools to help make plans accountable. The guide reported that the majority (53 percent) of HMO members are at least "very satisfied" with their health plans, but 14 percent are "unsatisfied."

Conclusions

Maryland is one of the nation's richest states and has a relatively high rate of employer-sponsored coverage. However, the state's uninsured rate is only slightly below average, in part because Medicaid enrollment is low and its population health indicators

are mixed. Maryland has expanded Medicaid to provide insurance coverage directly to low-income children through CHIP and has quickly enrolled a high proportion of eligibles. The state has pursued small-group insurance market reforms to improve access to private health insurance coverage and has enacted further individual market reforms as required by HIPAA.

Maryland has high HMO penetration rates in the private market and in Medicaid. The state has aggressively pursued mandatory Medicaid enrollment in HMOs to limit the program's expenditure growth. Hospital systems have actively sought mergers and affiliations to position themselves for contracts with large managed care plans; however, the state's all-payer rate-setting system has protected the hospital sector from the level of consolidations and layoffs seen in some other states. The rate-setting system, once a success in simultaneously holding down hospital costs and providing funding for uncompensated care, is now under fire. Policymakers are considering following the examples of other states and replacing it with a negotiated rate system.

Maryland's aggressive regulatory reforms—including insurance reforms, the only remaining hospital rate-setting system, extensive consumer protections and mandated benefits, and comprehensive health plan performance measurement—have prompted calls from policymakers and stakeholders to streamline regulatory oversight. During the 1998 legislative session, a proposal to consolidate regulatory authority in fewer agencies enjoyed widespread support but stalled over details. Such reforms seem likely to pass in the next legislative session. Whether they weaken the state's active commitment to regulate health care markets remains to be seen.

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